75-1698

Supreme Court, U. S.
FILED
MAY 24 1976
MICHAEL RODAK, JR., CLERK

In the Supreme Court of the United States

Term, 1976

THE WILLIAMSPORT HOSPITAL, and
THE HOSPITAL ASSOCIATION OF PENNSYLVANIA,

Appellants

v.

F. EMMETT FITZPATRICK, DISTRICT ATTORNEY,
ROBERT P. KANE, ATTORNEY GENERAL,
THE INSURANCE DEPARTMENT OF PENNSYLVANIA, and
BLUE CROSS OF GREATER PHILADELPHIA,

Appellees

JURISDICTIONAL STATEMENT

Appeal from the Final Decree of the United States District Court for the Eastern District of Pennsylvania.

NAUMAN, SMITH, SHISSLER & HALL
James H. Stewart, Jr.
Spencer G. Hall, Jr.
Attorneys for The Hospital Association of Pennsylvania and The Williamsport Hospital

Six North Third Street
P.O. Box 840
Harrisburg, Pennsylvania 17108

I N D E X

Table of Citations ..... (i)

Reference to Opinions Below.....1

Grounds for Jurisdiction 2

Questions Presented 4

Statement of the Case.....6

The Questions Presented are Substantial 11

Act 94 of 1975 Appendix

Lower Court Opinion Appendix

TABLE OF CITATIONS

CASES

Anderson v. Martin, 375 U.S. 359 (1964)..... 2

Begnaud v. White, 170 F 2d 323, 327 (6th Cir. 1948)

City of El Paso v. Simmons, 399 U.S. 497 (1965) 12

Crozen-Chester Medical Center v. Blue Cross of Greater Philadelphia, No. 9799 1974 Term, Del. Co. 7, 8

Day-Brite Lighting Inc. v. Missouri 342 U.S. 421 (1952) 15

Florida Lime & Avocado Growers, Inc. v. Jacobsen, 362 U.S. 73 (1960) 3

Home Building & Loan Association v. Blaisdell,290 U.S. 398 (1934) 13

Insurance Department v. Saint Lukes Hospital, Pa. Commonwealth Ct., 342 A 2 773 (1975) 11

St. John v. Wisconsin Employment Relations Bd. 340 U.S. 411 (1951) ... 3

Travelers Insurance Co. v. Blue Cross of Western Pennsylvania, 481 F2 80 (3rd Cir. 1973) 17

TABLE OF CITATIONS (Cont'd)

CONSTITUTIONAL LAW

Article 1, Section 10 4

14th Amendment 10

STATUTORY AUTHORITY

28 USC 1331, 1343(3), 2281 & 2284 2

Act of August 2, 1975, P.L. _____
Act No. 94, 40 P.S. Section 6124 2

JURISDICTIONAL STATEMENT

This is an appeal from the judgment of the United States District Court for the Eastern District of Pennsylvania sustaining the constitutionality of a statute of the Commonwealth of Pennsylvania and refusing injunctive and declaratory judgment relief. This statement is submitted pursuant to Rule 15 of the Rules of the Supreme Court to demonstrate that this Court has jurisdiction to consider the appeal and that substantial federal questions are involved herein.

Reference to Opinions Below

The District Court rendered its opinion in the case below on the basis of cross motions for summary judgment, oral argument and submission of briefs. The opinion is to date unreported; a copy of said opinion and a copy of the order issued therewith is attached hereto and set forth in the appendix.

Grounds of Jurisdiction

This action was instituted by Plaintiffs pursuant to Title 28 USC §§ 1331, 1343(3), 2281 and 2284. A court composed of three judges was instituted to hear this cause in the court below as provided by 28 USC §2284. On February 27, 1976, the court below entered its order sustaining the constitutionality of the Act of August 2, 1975, P.L.____, Act. No. 94, 40 P.S. §6124 and denying Plaintiff's request for injunctive relief. A notice of appeal to this Court was filed in the United States District Court for the Eastern District of Pennsylvania on the 24th day of March, 1976.

This is a direct appeal from the judgment of the three judge district court denying injunctive relief against the enforcement of a State Statute, a case required by Title 28 USC §§ 2281 and 2284 to be heard by a three judge court. This court has jurisdiction to consider this appeal under Title 28 USC § 1253. See Anderson v. Martin, 375 US 359 (1964);

Florida Lime & Avocado Growers Inc. v. Jacobsen, 362 US 73 (1960); St. John v. Wisconsin Employment Relations Bd., 340 US 411 (1951).

The text of Act 94 of 1975 of the Commonwealth of Pennsylvania, 40 P.S. § 6124 is attached hereto and set forth in the appendix.

QUESTIONS PRESENTED

The following questions are presented by this appeal:

1. Did the majority of the three-judge panel err in finding that Plaintiffs were not entitled to injunctive relief to prevent their property from being unconstitutionally taken without due process of law under Act No. 94 of 1975 by being forced to sell services to Defendant at less than the Defendant's pro rata share of the full financial requirements of Plaintiffsto operate their hospitals, including Plaintiffs' costs for charity patients, research, bad debts and other costs of doing business which Defendant refuses to reimburse?

2. Did the majority of the three-judge panel err in sustaining the constitutionality of Act No.94 of 1975 which violates Plaintiffs' contractual right to terminate the contract which had been fully terminated in violation of the contract clause of Article I, Section 10 of the United States Constitution?

3. Did the majority of the three judge panel err in finding hospitals are regulated in Pennsylvania?

4. Did the majority of the three judge panel err in granting Defendant's Motion for Summary Judgment without permitting Plaintiff to establish as fact the confiscatory nature of payments under Act 94 of 1975 and Plaintiffs' right to payment of Defendant's pro rata share of Plaintiffs' full financial requirements?

Statement of the Case

In July of 1971, Blue Cross of Greater Philadelphia and Delaware Valley Hospital Council, representing Plaintiff hospitals, negotiated and entered into a contract of "Hospital Agreement" which agreement was to reamin in force for two years, but was terminable by either party upon 90 days notice. This agreement provided that member hospitals would receive "reasonable cost" reimbursement under which the hospitals were to be paid what Blue Cross considered cost of services rendered to Blue Cross subscribers. In determining "reasonable cost" the Blue Cross formula excluded from consideration real costs of operating the hospitals, including in particular care for patients unable to pay their bills but not eligible for state medical assistance, and bad debts.

The parties had not been able to negotiate a new contract when the Hospital Agreement, as amended, terminated on July 1, 1973. They continued to negotiate, however, and in February, 1974, agreed to a "Summary of Principles" retroactive to the July 1, 1973, ter-

mination date as the basis for an ongoing contractual relationship. The Summary of Principles basically continued in effect with some minor modifications until March 31, 1974, the previous Hospital Agreement as modified by the Amendment of July 1, 1972.

When the parties failed to reach agreement on a new contract by March 31, 1974, the Agreement, as modified and extended by the Summary of Principles, terminated and a ninety-one day "continuation" period commenced. By agreement, this "continuation" period was extended for an additional 31 days until July 31, 1974. On August 1, 1974, the hospitals rejected Blue Cross' attempt to unilaterally extend the Agreement to August 15, 1974.

Meanwhile, price controls having ended in April, 1974, the hospitals filed a complaint in Crozer-Chester Medical Center, et al v. Blue Cross of Greater Philadelphia, No. 9799, 1974 Term (C.P. Del. Co.), to require Blue Cross to pay "reasonable costs" without a ceiling for the twelve-month period

following termination of the contract, during which hospitals had agreed in the contract to treat, as if under the contract, patients whose current annual Blue Cross contract was in effect on the date of termination. This period is called the run-out period, and fewer and fewer subscribers are eligible as the year goes on. A settlement was reached in the Crozer-Chester case (Order of September 25, 1974), which set the run-out period from August 15, 1974, to August 15, 1975, and provided for increased interim rates during this period and full allowable costs with no ceiling upon a final accounting. When the run-out period ended on August 15, 1975, the hospitals would have been able to recover the full costs of treating all Blue Cross subscribers by billing them directly, but for Act No. 94 which was signed effective immediately on August 2, 1975. All subscribers but those who contracted between August 2, 1974, and August 14, 1974, or thirteen days, were already outside the contract.

At the time Act No. 94 went into effect,

contracts similar to the termianted Delaware Valley Agreement were still in effect between plaintiff-intervenor Willimsport Hospital and other members of plaintiff hospital class and Hospital Service Corporation of Northeastern Pennsylvania, a hospital plan corporation.

The Questions Presented Are Substantial

The questions presented are substantial and require plenary consideration for their resolution.

Two judges of a three-judge Federal Court have sustained the constitutionality of Act No. 94 of 1975 by granting Defendant's Motion for Summary Judgment, for their stated reasons that the Act does not (1) violate the Contract Clause of the United States Constitution, Article I, Section 10, due to the substantial public interest in the area of hospital care; (2) contravene the Due Process Clause of the Fourteenth Amendment; and (3) infringe upon Plaintiffs' right to equal protection of the law because the statutory scheme has a "rationale basis".

The effect of Act No. 94 on the Plaintiff hospitals is to retroactively reinstate a lawfully terminated contract between Plaintiff hospitals and Blue Cross of Greater Philadelphia. The Act, as Judge Luongo recognizes in his dissent, fails to

provide for compensation to Plaintiff hospitals for losses sustained by them during the period of enforced adherence to the terms of the previously negotiated and terminated contract, thereby not only infringing on the contract clause but also taking property without just compensation. While apparently recognizing that the Act does not provide compensation to hospitals for losses incurred during the period of extension, the majority of the Lower Court concluded that the health of the citizens of Pennsylvania, as a matter of public policy, justifies such a measure. Furthermore, the Lower Court concluded that Act No. 94 only extends the previously terminated contract for one year and that, therefore, the contract is terminable by the hospitals without penalty.

Significantly, we are here concerned with a contract that had been lawfully terminated for a period of one year prior to the enactment of Act No. 94. While it is true that under the terminated contract certain "run-out" procedures were in effect, the basic fact remains that the contract had been

terminated and thus there is insufficient nexus between the contracts and the statute to effectuate a retrotive reinstatement. But for the "run-out" period, the reinstatement in the instant case would be analogous to a legislative attempt to reinstate the Blue Cross Lehigh Valley contract that was terminated on July 1, 1972. It is one thing to legislatively extend a contract currently in effect -- assuming property is not thereby unconstitutionally taken without due process of law -- it is another to reinstate a contract that is not in effect, and one that has been terminated.

Fortunately, in the Lehigh Valley areas the hospitals entered into new contracts after a judicial determination that the Insurance Department's authority to monitor their contracts was limited to approval of rates and matters affecting rates. Insurance Department of Pennsylvania v. Saint Lukes Hospital, ____ Pa. Commonwealth Ct. ____, 342 A2d 773 (1975).

It cannot be gainsaid that the legislature has the power to enact legislation to protect the public health, safety, and welfare and that assuring

the availability of hospital care is beyond their power, however, the legislature cannot fulfill this responsibility at the expense of private institutions without providing just compensation to such institutions.

The Lower Court relies on City of El Paso v. Simmons, 399 US 497 (1965), as standing for the propositions that the legislature has the power to safeguard the vital interests of its citizenry and that in furtherance of that end it has greater latitude to effect contractual rights if the legislation concerns the health and welfare of the people as opposed to purely commercial enterprises. As a general rule, what the Lower Court states is true; however, within the factual context of the instant case, the El Paso decision is inapposite because the statute there at issue did not inviserate a fundamental, substantive contractual right, but rather reasonably delineated the procedural mechanism for enforcement of that right.

As this Court stated in El Paso, the Opinion in Home Building & Loan Assn. v. Blaisdell, 290 US 398

(1934), makes it clear that under the guise of protecting the public welfare the state cannot "adopt as its policy the repudiation of debts or the destructions of contracts or the denial of means to enforce them". In Blaisdell, this Court was confronted with a Minnesota statute that retroactively extended the period during which a defaulting mortgagor could redeem property which had been foreclosed. Although the contract rights of the parties were altered, the substantive rights were not impaired because the defaulting mortgagor was required to pay the mortgagee a fair rental value for the property while he remained in possession. Consequently, the mortgagee suffered no pecuniary loss.

In the instant case, Act No. 94 makes no such allowance for compensating Plaintiff hospitals and the retroactive extension of the terminated contracts mandates that Plaintiff hospitals operate at a loss. Since Plaintiff hospitals are not for profit institutions it is not a question of reducing their net rate of return, but rather of requiring

said hospitals to operate at a loss. Accordingly, the Lower Court's reliance on Day-Brite Lighting Inc. v. Missouri, 342 US 421 (1952), is misplaced.

The importance of the right of a hospital to compensation for its real cost of operating the hospital is of national importance and effects every hospital in the Commonwealth of Pennsylvania with Blue Cross contracts in effect. One of the basic disagreements which created the impasse which lead to Act No. 94 of 1975 was the demand by hospitals that Blue Cross recognize the need for their subscribers, as members of the community, to bear their fair share of the cost for charity patients who cannot pay, for bad debts, and for education and reasearch.

"Reasonable cost", as defined by Blue Cross, is arrived at by deciding inpatient costs of operating the hospital by patient days and paying only for eligible, properly utilized patient days of subscribers. This system throws off ineligible or misutilized days of subscribers to be borne by others if their subscribers cannot pay, and carries no part of the community

obligation to care for the indigent.

Medicare and Medicaid likewise refuse to carry any of the burden for indigent care for persons not within their programs, and they likewise throw off ineligible or misutilized patient days. The full burden of costs, therefore, falls on the small segment of hospital users who are self-pay or commercially insured. Hospital charges which are paid only by this segment are substantially inflated so that about a quarter of the charges in most hospitals must carry the full burdens of free patient care and bad debts.

It is the position of Blue Cross that the state is responsible for free care if it is to be given to indigents and that its subscribers have none of the community burden in this regard. The state has not only a level of eligibility for medical assistance below the level of need, but it fails to pay its share of the burden for the services its recipients are furnished for fiscal or other reasons. Medical costs can easily exceed the ability to pay of modest

wage earners in ~~services~~ serious or protracted illnesses.

Judge Luongo fully perceived and well states this problem in his dissenting opinion in the Lower Court. Even the majority do not deny that it would be unconstitutional to retroactively or prospectively impose a duty on hospitals to furnish services at less than cost. They avoid the due process issue first by stating that such contractual terms were found valid in Travelers Insurance Company v. Blue Cross of Western Pennsylvania, 361 F.Supp. 774 (W.D. Pa. 1972) aff'd, 481 F.2d 80 (3d Cir. 1973) cert. denied, 414 U.S. 1093 (1974), and ~~secured~~ second by treating these costs as gratuitous services to the community ~~and~~ undertaken by hospitals.

As to the validity of the contracts in Travelers, supra, they were found valid only as not creating a violation of the anti-trust laws, if they were state imposed. No one contended that hospitals were being deprived of property, indeed the hospitals in that case supported Blue Cross. The propriety of the

provisions found to be mandated was left to the state free from anti-trust restrictions. There is no evidence in this case that the terms of the July 1, 1972, contract were mandated by the state.

The same provisions were agreed to by Plaintiffs in the terminated contracts. They are now contended to be confiscatory and that is why the contracts were terminated. They are confiscatory if one accepts the fact that they are necessary costs of operating a hospital. As confiscatory terms, they cannot be imposed by the state even under the guise of its interest in public health under the police or welfare powers. Act No. 94 imposes such terms ~~as that~~ without providing compensation for the resulting losses to Plaintiffs. This violates the due process clause of the Fourteenth Amendment.

Plaintiff hospitals also contend that Act No. 94 is violative of the equal protection clause of the Fourteenth Amendment because it discriminates between hospitals who had entered into contracts with Blue

Cross, "member hospitals" and those who did not. Nonmember hospitals, treating Blue Cross subscribers, receive a predetermined amount from Blue Cross and the excess is billed to the patient directly thereby assuring the provider hospital that they will receive full cost reimbursement while member hospitals will not. The Lower Court sustains this statutory scheme on a "rational basis" test, concluding that because "of the substantial difference in subscriber benefits provided by member and nonmember hospitals here, it cannot be gainsaid that the statutory distinction has no reasonable basis". They only "substantial difference in subscriber benefits" is the amount and manner of payment and is unrelated to the treatment or service or benefits the patient/subscriber receives from the member or nonmember hospital. Resolutions of the equal protection argument in such a manner assumes the very issue before the Court, i.e., that it is permissible to reimburse some hospitals at full cost and others at less than cost.

Finally, Plaintiff hospitals contend that Defendant's Motion for Summary Judgment should not

have been granted because material issues of fact are inddispute. The majority of the Lower Court found, on considering Plaintiffs' Motion for Summary Judgment, that Plaintiffs' depositions, submitted incident to its motion, were too general to support their Motion. Although Plaintiffs' depositions may have been too general to support their Motion, and although Plaintiffs, in their Motion, averred that no material facts were in dispute, it does not necessarily follow that the Lower Court can enter judgment on Defendant's Motion. Clearly, the recital of the depositions in the majority's opinion shows that they raised a substantial issue of fact to which Plaintiffs should have been permitted to proceed to trial. That Plaintiffs' depositions are too general to support their Motion does not necessarily mean that there is an absence of material facts in dispute. On the contrary, any inference to be derived therefrom is that Plaintiffs should be allowed to proceed to trial. In Begnaud v. White, 170 F2d 323, 327 (6th Cir. 1948), the import of cross motions for summary was concisely and ably discussed:

"The fact that both parties make motions for summary judgment, and each contends in support of his respective motion that no genuine issue of fact exists, does not require the court to rule that no fact issue exists. Each, in support of his own motion, may be willing to concede certain contentions of his opponent, which concession, however, is only for the purpose of the pending motion. If the motion is overruled, the concession is no longer effective. Appellants' concession that no genuine issue of fact existed was made in support of its own motion for summary judgment. We do not think that the concession continues over into the court's separate consideration of appellee's motion for summary judgment in his behalf after appellants' motion was overruled."

We submit that Act No. 94 is unconstitutional and that the Order of the Lower Court should be reversed.

Respectfully submitted,

NAUMAN, SMITH, SHISSLER & HALL

By_____
James H. Stewart, Jr.

Spencer G. Hall, Jr.

CERTIFICATE OF SERVICE

I, JAMES H. STEWART, JR., ESQUIRE, of the law firm of NAUMAN, SMITH, SHISSLER & HALL, attorneys of record for the Plaintiffs herein, depose and say that on the 24th day of May, 1976, I served a copy of the foregoing Jurisdictional Statement on attorneys of record herein, by depositing copies of the same in the United States mail, postage prepaid, at Harrisburg, Pennsylvania, addressed to:

JAMES D. CRAWFORD, Esquire
Schnader, Harrison, Segal & Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102
Attorney for Paul I. Guest, Charles H. Frenzel, Philip J. Sawlinsky, Methodist Hospital and Delaware Valley Hospital Council.

BONNIE BRIGANCE LEADBETTER, Esquire
Assistant District Attorney
22nd Floor - 5 Penn Center Plaza
Philadelphia, Pennsylvania 19102
Counsel for Defendant F. Emmett Pitzpatrick

LAWRENCE I. WASHOR, Esquire
2100 Fidelity Building
Philadelphia, Pennsylvania 19109
Counsel for Defendant Blue Cross of Greater Philadelphia

James H. Stewart, Jr.

APPENDIX
SESSION OF 1975

NONPROFIT HOSPITAL INSURANCE PLANS

ACT NO. 94

H.B.NO.1347

An Act amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, adding provisions relating to contractual relationships between hospital plan corporations and hospitals, providing for the maintenance of such contractual relationship during disputes, authorizing the Insurance Department to take certain action with respect thereto, and providing for the temporary restoration of certain lapsed contractual relationships.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1.

Section 6124 of Title 40, act of November 25, 1970 (P.L. 707, No. 230), known as the Pennsylvania Consolidated Statutes, added November 15, 1972 (P.L. 1063, No. 271), is amended by adding a subsection to read:

§ 6124. Rates and contracts

* * *

(c) Maintenance of contractual relationships.--

(1) Declaration of necessity.--It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. It is hereby declared to be essential for the maintenance

of the health of the residents of this Commonwealth that subscribers to nonprofit hospital plans be assured receipt of the hospitalization and related health benefits prepaid by them through payment of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish this essential purpose termination of contracts between hospital plan corporations and hospitals entered into pursuant to section 6121 (relating to eligible hospitals) and this section be subject to prior approval by the department as provided in this subsection.

(2) Notification period.--No contract between a hospital plan corporation and any hospital providing for the rendering of hospitalization to subscribers to the hospital plan shall be terminated unless the party seeking such termination gives 90 days advance written notice to the other party to the contract and to the department of the proposed termination.

(3) Hearing period.--Whenever a termination subject to paragraph (2) involves contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the department shall hold public hearings on at least 15 days notice for the purpose of investigating the reasons for the termination. Pending completion of said investigation by the department, termination of the hospital contracts shall be suspended for a period not to exceed six months from the expiration of the period provided for in paragraph (2). All terms and conditions of the contract between the hospital plan corporation and the hospital or hospitals shall continue in full force and effect during said investigation by the department. Based on the record made during the hearings, the department shall make specific findings as to the facts of the dispute and shall either approve termination of the

contracts or recommend such terms for continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost.

(4) Negotiation period.--If the department recommends terms for continuation of the contract, the hospital plan corporation and the hospitals involved shall renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms for continuation recommended by the department and pending such negotiations, the termination of the hospital contracts shall be suspended for a further period not to exceed 90 days from the date of the decision of the department. If the hospital plan corporation and the hospitals are unable to consummate a new contract within said further period of 90 days, they shall so advise the department. The department shall in that event approve termination of the contracts effective at the end of a further period of 30 days and shall prescribe the form and extent of notice which the hospital plan corporation shall use in advising its subscribers that hospitalization in the hospitals involved is not covered by a contract between the hospital plan corporation and such hospitals.

(5) Retroactivity.--Upon the settlement of any dispute between a hospital plan corporation and any hospital pursuant to paragraphs (2) and (4), the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties.

Section 2.

The procedures established by this act shall apply to:

(1) any termination of contracts between hospital plan corporations and hospitals hereafter occurring; and

(2) any contracts between hospital plan corporations and hospitals under which subscribers received prepaid benefits on or after June 30, 1974 if such hospital plan corporations and hospitals were governed by contracts subject to 40 Pa.C.S. Chap. 61 (relating to hospital plan corporations) or corresponding provisions of law on June 30, 1964 and substantially continuously thereafter to and including June 30, 1974. Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.

Section 3.

This act shall take effect immediately and shall be retroactive to the extent provided in section 2 of this act.

Approved the 2nd day of Aug. A.D. 1974.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PAUL I. GUEST, President of Methodist Hospital; CHARLES H. FRENZEL, Executive Vice President of Mercy Catholia Medical Center; PHILIP J. SAWLINSKY, Manager of Patient Accounts of ST. JOSEPH'S HOSPITAL; and METHODIST HOSPITAL, on behalf of themselves and all others similarly situated	:	CIVIL ACTION
v.	:	
EMMETT F. FITZPATRICK, JR., District Attorney of Philadelphia, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvanis, Individually and in their Official Capacities, and BLUE CROSS OF GREATER PHILADELPHIA	:	NO. 75-2306

BEFORE VAN DUSEN, Circuit Judge, and LUONGO and WEINER, District Judges

WEINER, J. FEBRUARY 27, 1976

This is an action brought by several hospitals, members of the Delaware Valley Hospital Council (hereinafter DVHC) for declaratory judgment and injunctive relief, challenging the provisions of a Pennsylvania law, Act No. 94, 40 Pa. C.S. §6124(c), effective August 2, 1975. Act No. 94 creates statutory requirements for the

termination of contracts between hospitals and certain hospital plan corporations. Jurisdiction of this Court was invoked pursuant to 28 U.S.C. § 1331, and 28 U.S.C. § 1343(3), and a three-judge court was convened as required by 18 U.S.C. §2284. The court has for its consideration cross motions for summary judgment filed by plaintiffs and defendants respectively.[1]

Since the facts are not in dispute, there remain solely questions of law. From our examination of the record, the following facts emerge: On August 15, 1974, the contract between defendant Blue Cross of Greater Philadelphia and plaintiff hospitals expired. Run-out provisions of the

---

1. Due to a stipulation filed 9/25/75, stating that defendants Fitzpatrick and Kane agree not to seek criminal sanctions while Act. No. 94 remains subject to constitutional challenge but apparently reserving their right to proceed against plaintiffs after final determination of this suit, there is a case or controversy continuing insofar as plaintiffs seek final injunctive relief. The absence of any demand for damages requires that the Pennsylvania defendants' claims for immunity under the Eleventh Amendment be rejected. See Edelman v. Jordan, 415 U.S. 651, 664-65 (1974).

contracts between Blue Cross and individual subscribers then began to take effect, and coverage expired on the anniversary dates of the subscription contracts. The last subscriber contracts were to run out on August 15, 1975. During the one-year following expiration of the above contract, negotiations toward a new contract proved to be unsuccessful. The effect of the run-out provisions would have been to limit most subscribers' coverage to that afforded in non-Blue Cross member hospitals. Traditionally, an individual enters into a subscription contract with Blue Cross. In the majority of cases, the insurance plan will obtain hospital services in member hospitals. The coverage afforded is then either complete coverage, i.e., the full hospital service is provided, or the subscriber pays a relatively small portion of the hospital fee. In either event, Blue Cross makes direct payment to the hospital. If the subscriber is admitted to a hospital which is not a member hospital, the subscriber will be fully responsible for his hospital costs and Blue Cross will partially

reimburse the subscriber directly. Typically, only a small portion of the total hospital bill is repaid to the subscriber.

In situations in which total coverage is provided subscribers, it is clearly necessary that there be a contractual relationship between Blue Cross and the hospitals. Hence, the term "member hospitals". The contract between Blue Cross and its member hospitals operates on a cost reimbursement formula. Under such a formula, the retail price of hospital services is not paid by Blue Cross. Rather, Blue Cross reimburses hospitals for the cost to the hospitals of providing care to the subscriber, computed in a way that allows, inter alia, for consideration of depreciation and economic inflation factors.

It was the cost reimbursement formula that led to the breakdown of negotiations for new contracts between Blue Cross and the plaintiff hospitals who are represented by the DVHC.

During the one-year period of negotiations, increasing numbers of subscribers lost member

hospital benefits in the plaintiff hospitals. On August 2, 1976, the Pennsylvania legislature passed, and the Governor signed, Act No. 94, 40 Pa. C.S. § 6124(c).

Chapter 61 of Title 40 establishes statutory control over hospital plan corporations. Defendant Blue Cross of Greater Philadelphia is a hospital plan corporation within the meaning of the statute. The Hospital Plan Corporation Act generally provides for regulation of hospital plan corporations and specifically requires, inter alia, that all hospital plan corporations obtain certificates of authority from the Pennsylvania Department of Insurance (§ 6102(a)); that hospital plan corporations enter into contracts only with hospitals approved by the Department of Public Welfare. (§ 6121).

Section 6124 of the Hospital Plan Corporation Act, which section Act No. 94 amends, provides:

> (a) The rates charged to subscribers by hospital plan corporations, all rates of payments to hospitals made by such corporations pursuant to the contracts provided for in this chapter, all acquisition costs in connection with the solicitation of subscribers to such hospital plans, the reserves

to be maintained by such corporations, the certificates issued by such corporations representing their agreements with subscribers, and any and all contracts entered into by any such corporation with any hospital, shall, at all times, be subject to the prior approval of the department.
(b) Every application for such approval shall be made to the department in writing . . .

Act No. 94 which amends the above section, provides:

Section 1. Section 6124 of Title 40, . . . is amended by adding a subsection to read:

§ 6124. Rates and contracts

. . .

(c) Maintenance of contractual relationship.

(1) Declaration of necessity - It is hereby found that many subscribers to nonprofit hospital plans make payments over long periods of time prior to becoming entitled to benefits under such a plan and that it is important in the public interest that the reasonable expectations of such subscribers as to coverage should be fulfilled if possible. It is hereby declared to be essential for the maintenance of the health of the residents of this Commonwealth that subscribers to non-profit hospital plans be assured receipt of the hospitalization and related health benefits prepaid by them through payments of the rates approved under this chapter and charged by a hospital plan corporation and that to accomplish

this essential purpose termination of contracts between hospital plan corporations and hospitals entered into pursuant to section 6121 (relating to eligible hospitals) and this section be subject to prior approval by the department as provided in this subsection.

(2) Notification period - No contract between a hospital plan corporation and any hospital providing for the rendering of hospitalization to subscribers to the hospital plan shall be terminated unless the party seeking such termination gives 90 days advance written notice to the other party to the contrary and to the department of the proposed termination.

(3) Hearing period - Whenever a termination subject to paragraph (2) involves contracts with hospitals having more than 5% of the beds in the area served by a hospital plan corporation, the department shall hold public hearings on at least 15 days notice for the purpose of investigating the reasons for the termination. Pending completion of said investigation by the department, termination of the hospital contracts shall be suspended for a period not to exceed six months from the expiration of the period provided for in paragraph (2). All terms and conditions of the contract between the hospital plan corporation and the hospital or hospitals shall continue in full force and effect during said investigation by the department. Based on the record made during the hearings, the department shall make specific findings as to the facts of the dispute and shall either approve termination of the contracts

or recommend such terms for continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost.

(4) Negotiation period - If the department recommends terms for continuation of the contract, the hospital plan corporation and the hospitals involved shall renew their negotiations in order to determine whether a new agreement can be reached substantially on the basis of the terms for continuation recommended by the department and pending such negotiations, the termination of hospital contracts shall be suspended for a further period not to exceed 90 days from the date of the decision of the department. If the hospital plan corporation and the hospitals are unable to consummate a new contract within said further period of 90 days, they shall so advise the department. The department shall in that event approve termination of the contracts effective at the end of a further period of 30 days and shall prescribe the form and extent of notice which the hospital plan corporation shall use in advising its subscribers that hospitalization in the hospitals involved is not covered by a contract between the hospital plan corporation and such hospitals.

(5) Retroactivity - Upon the settlement of any dispute between a hospital plan corporation and any hospital pursuant to paragraphs (2) and (4), the terms and conditions of any new contract shall be retroactive to the

> date of expiration of the contract previously in effect between the parties.

Section 2. The procedures established by this act shall apply to:

> (1) any termination of contracts between hospital plan corporations and hospitals hereafter occurring; and (2) any contracts between hospital plan corporations and hospitals under which subscribers received prepaid benefits on or after June 30, 1974 . . . . Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act.

Section 3. This act shall take effect immediately and shall be retroactive to the extent provided in section 2 of this act.

The effect of Act No. 94 on the Plaintiff hospitals is to reinstate the most recent contract between the DVHC represented hospitals and Blue Cross as of its original termination date, namely, August 15, 1974. If the hospitals wish to terminate the contract, they must follow the provisions of the Act. If a new contract is negotiated by the parties and approved by the Insurance Department, that new contract will date back to the termination

of the previous agreement. However, since August, 1974,[2] the hospitals have been requiring Blue Cross subscribers to pay for hospital care as is the practice in non-member hospitals. The hospitals are now faced with the prospect of repaying those subscribers and receiving only cost reimbursement from Blue Cross under the 1971 contract.[3]

The hospitals' contention is that Act No. 94 violates their Constitutional rights. They claim that the retroactivity of the Act, which reinstates the contract which expired on August 15, 1974, is in violation of the Contract Clause and of the Due Process Clause of the United States Constitution. Specifically, the hospitals claim that the Act effects an unconstitutional taking of property without just compensation and also violates the Equal Protection Clause of the United States Constitution.

---

2. This date, is, of course, variable, because of the run-out provisions of subscribers' contracts.

3. The contract which expired on August 15, 1974 was entered into in 1971 and amended in 1972.

The Contract Clause, Article I, § 10 of the United States Constitution provides that no State shall pass any law impairing the obligation of contracts. The plaintiff-hospitals' contention is that Act No. 94 constitutes a "wholesale evisceration of plaintiffs' contractual rights of termination." We believe that this is not the case at all here.

The Contract Clause came into widespread use in litigation during the depression years when many States passed statutes designed to aid financially distressed citizens, unable to satisfy previously entered-into contractual obligations. The case of Home Building and Loan Assn. v. Blaisdell, et al., 290 U.S. 398 (1933) sets forth the standards to be applied to state legislative enactments to determine whether or not such legislation offends the Contract Clause. At issue in that case was the 1933 Minnesota Mortgage Moratorium Law which provided relief from mortgage foreclosure during a declared emergency. In its opinion upholding the statute, the Supreme Court stated:

> "Not only are existing laws read into contracts in order to fix obligations as between the parties, but the reservation of essential attributes of sovereign power is also read into contracts as a postulate of the legal order. The policy of protecting contracts against impairment presupposes the maintenance of a government by virtue of which contractual relations are worthwhile, - a government which retains adequate authority to secure the peace and good order of society. The principle of harmonizing the constitutional prohibition with the necessary residuum of state power has had progressive recognition in the decisions of this Court." Id. at 435.

The plaintiffs' argument is, in essence, that the statutory extension period violates their contract right of termination on ninety days notice as to any contract entered into between the hospitals and Blue Cross. We are of the opinion that the public interest of preserving the health of the citizens of Pennsylvania adequately justifies such a measure.[4]

---

4. The case of Travelers Insurance Co. v. Blue Cross of Western Pa., 361 F. Supp. 774 (W.D. Pa. 1972), aff'd 481 F. 2d 80 (3d Cir. 1973), cert. denied 414 U.S. 1093 (1974), sustained the general provisions of Blue Cross-hospital contracts against charges of violation of the antitrust laws. In that case, it was stated that a study of the health care

More than 50% of the citizens have health care insurance coverage through Blue Cross. Most, if not all, of these policyholders, it can be assumed, maintain Blue Cross insurance because of the virtually complete coverage offered by Blue Cross at member hospitals. The current contract dispute, with the resulting run-out of subscribers' member hospital coverage eliminated many hospitals in the Philadelphia area from member hospital status.[5]

The maintenace of the health and general well-being of its citizens has been found to be a legitimate state concern and has formed the basis of numerous judicial decisions upholding state

---

4. (footnote continued)
problem in Pennsylvania by the Pennsylvania Economy League showed that " . . . it was common for people to forego needed hospitalization because they lacked money to pay the bills." 361 F. Supp. 774, 776.

5.
Thirty-seven (37) hospitals in the Philadelphia area are represented by the DVHC. Non-member hospital coverage for subscribers is approximately 25% of hospital costs.

legislative action.[6] Likewise, in this case, it is precisely because the public interest is so substantial in the area of health care that legislation governing hospitals and hospital plan corporations has been enacted in Pennsylvania.[7] Act No. 94 is a logical and reasonable extension of that legislation.

We have carefully considered the cases cited by our brother Judge Luongo and find them to be distinguishable.[8] The Supreme Court, in El Paso v. Simmons, 379 U.S. 497 (1965) stated that it has long been recognized that state legislatures have the power to safeguard the vital interests of their citizenry.[9] The distinction to be drawn is not

---

6. See e.g., Nebbia v. New York, 291 U.S. 502 (1934) in which regulation of the sale price of milk authorized by a New York statute was upheld as being reasonably related to the goal of protecting the welfare of the citizens of New York. In its opinion, the Supreme Court stated that support for this statute could be found from the fact that the milk industry in general was heavily regulated in New York.

7. 40 Pa. C.S. § 6101, et. seq.

8. (Continued next page.) (Also 9.)

solely between legislation of substantive and remedial contract provisions but, rather, between legislation which affects contractual rights and obligations in purely commercial enterprises and legislation which concerns the health and welfare of the people. The need of Pennsylvanians for medical insurance whic h enables them to receive hospital care during health crises is a need which will, unfortunately, touch most citizens during their lifetimes. The public interest underlying Act No. 94 clearly justifies any incursions it makes into the contract rights of the parties here.

In Fornaris v. Ridge Tool Co., et al., supra, the Court of Appeals found unconstitutional a

---

8.
Fornaris v. Ridge Tool Co., et al., 423 F. 2d 563 (1st Cir. 1970), rev'd. on other grounds, 400 U.S. 41 (1971); Superior Motors, Inc. v. Winnebago Industries, Inc., 359 F. Supp. 773 (D. S.C. 1973).

9.
Id. at 508.

Puerto Rican statute which provided that contracts between manufacturers and dealers, regardless of their terms, were, with certain exceptions, to be renewable at the option of the dealer and which imposed substantial damages on manufacturers who refused to accede. The court found that the new contractual obligations were excessive in light of the reasonable expectations of the parties. Here in contrast the contracts are still terminable at the end of approximately one year by the hospitals without penalty and their expectations, as a regulated industry are different from those of the commercial manufacturers in Fornaris.

Plaintiffs further contend that Act No. 94 violates the Due Process and Equal Protection Clause of the United States Constitution. Their argument is based in part on the theory that the cost reimbursement formula contained in the Blue Cross-hospital contracts does not include such items as indigent care, charity allowances, uncollectible amounts or research costs and thereby renders the contracts non-compensatory and constitutes a taking

of property without just compensation. The validity of such clauses in Blue Cross-hospital contracts has already been upheld.

The case of Travelers Insurance Company v. Blue Cross of Western Pennsylvania, supra, upheld Blue Cross-hospital contracts against claims by a commercial insurer that the contractual arrangements between Blue Cross of Western Pennsylvania and hospitals violated the antitrust laws. Specifically, Travelers contended that Blue Cross was a dominant competitor monopolizing the hospital insurance industry by pressuring hospitals to enter into contractual arrangements which favored Blue Cross over other commercial insurers. The favored treatment claim arose from the failure of Blue Cross-hospital contracts to include in the reimbursement formula such items as indigent care, and the resulting lower cost to Blue Cross for hospital services. The court, in its opinion, upholding the above-mentioned contract clauses stated that the Insurance Department had mandated a ceiling on cost reimbursement, and the exclusion from the reimbursement formula of the

cost of free care and capital expansion. We see nothing in the challenge to cost reimbursement formula in the instant case to distinguish it from the reimbursement terms found to be valid in Travelers.

We note that the court stated with reference to the Pennsylvania Hospital Plan Corporation Act (40 Pa. C.S.A. § 6106 ff.) in Travelers, supra, at page 86 of 481 F. 2d:

> "In view of our holding that, independent of the McCarran-Ferguson Act, the antitrust laws were not violated, the state of Pennsylvania has not denied Travelers equal treatment in violation of the Fourteenth Amendment. Furthermore, even if McCarran-Ferguson Act protection were necessary to Blue Cross, the facts do not support the proposition that Pennsylvania's regulation of the contract between Blue Cross and the hospitals was without rational purpose, see, e.g., James v. Strange, 407 U.S. 128, 92 S.Ct. 2027, 32 L.Ed. 2d 600 (1972)."

In addition, plaintiffs claim that the loss sustained by virtue of the fact that the above-mentioned costs are not reimbursed is further exacerbated by the ceiling limitation on reinstatement

of allowable costs. The question of the economic viability of hospitals as a result of the reinstatement of the previously-terminated contract is a matter for the legislative process as distinguished from judicial inquiry. Under the Hospital Plan Corporation Act, the Insurance Department is authorized to approve or disapprove proposed contracts pursuant to specific guidelines.[10] Act No. 94 itself provides that during the suspension period, the Insurance Department shall either approve termination of the contract or shall " . . . recommend such terms of continuation of the contract as are in the public interest, based upon the facts, the right of a hospital to be paid its costs for hospitalization services to subscribers and the need of subscribers for efficient, reliable hospitalization at a reasonable cost."[11] Plaintiff hospitals have filed a Notice of Intent to Terminate with the Insurance Department and have so notified Blue Cross.

---

10. 40 Pa. C.S. § 6124(a) & (b).

11. 40 Pa. C.S. § 6124(c)(3).

Therefore, the question of the non-compensatory nature of the reinstated contract is one to be determined by the Insurance Department.

Plaintiffs argue that Act No. 94 is subject to challenge on constituional grounds predicated upon the theory that the retroactive application of the statute constitutes a taking of property without due process and plaintiffs further reiterate their previous argument of "impairment of contract." Here, the plaintiffs focus upon the provisions of Act No. 94 which, in substance and effect, provide: (a) that contracts between the hospitals and Blue Cross which terminated in August 1974 be reinstated and (b) that, as a result, subscribers who paid in full for hospitalization during the eleven and a half month period preceding the passage of Act No. 94 be reimbursed for all charges which would have been reimbursed to subscribers under the 1971 Agreement. We find that the statutory reinstatement of terminated contracts and their cost reimbursement formulae and the resulting mandatory reimbursement of subscribers are not unconstitutional.

The unanticipated inability of Blue Cross and the hospitals to negotiate a new contract in 1974 created extreme financial hardship for Blue Cross subscribers hospitalized after the contractual run-out provisions had taken effect. Act No. 94 is designed to avoid the recurrence of such a situation in the future. As part of the remedial nature of the statute, hospitals with long-standing contracts with Blue Cross were required to reinstate the most recent contract provisions. This remedial measure is strikingly similar to remedial measures in other regulatory statutes regarding disputed rates charged by regulated corporations.[12] In Fleming v. Rhodes, 331 U.S. 100 (1947), the Supreme Court held that rights previously acquired can be legislatively reinstate retroactively. Here, subscribers contracted with and prepaid Blue Cross for health care coverage. As part of that contract, hospitalization at member hospitals was to be provided at

---

12.

For example, the Interstate Commerce Act, 49 U.S.C. § 15(7) authorizes the ICC to require that carriers refund, with interest, increased rates found to be not justified. And, in Nebbia v. New York, supra, a New York statute authorizing the Milk Control Board to fix milk prices in the state was upheld.

little or no cost to the subscriber. The crisis created by the failure of contract negotiations between Blue Cross and the hospitals placed a heavy burden on subscribers. Act No. 94, in its declaration of necessity, states that subscribers are entitled to receive benefits for which they have paid in advance. The subscribers hospitalized between August, 1974 and August, 1976 did not receive those health care benefits. Act No. 94 simply places them in the same position as subscribers hospitalized prior to August, 1974 and subsequent to August, 1975.

The retroactive effect of statutes has been approved where they have filed gaps in the regulatory scheme. See Fleming v. Rhoades, supra; C. Hochman, "The Supreme Court and the Constitutionality of Retroactive Legislation," 73 Harv. L. Rev. 692 (1960). The Supreme Court has recognized in the labor field that contractual arrangement may be "continued for a time while further efforts [are] made to settle the dispute." See Steelworkers v. United States, 361 U.S. 39, 41 (1959). Further,

the Supreme Court has held that the taking of property under a program clearly in the public interest is not a denial of due process of law, using this language in Day-Brite Lighting, Inc. v. Missouri, 342 U.S. 421, 424-25 (1952):

> "Of course many forms of regulation reduce the net return of the enterprise; yet that gives rise to no constitutional infirmity. [Citing cases.] Most regulations of business necessarily impose financial burdens on the enterprise for which no compensation is paid. Those are part of the costs of our civilization . . . The public welfare is a broad and inclusive concept. The moral, social, economic, and physical well-being of the community is one part of it; the political well-being another. The police power which is adequate to fix the financial burden for one

> is adequate for the other. The jusgment of the legislature that time out for voting should cost the employee nothing may be a debatable one. It is indeed conceded by the opposition to be such. But if our recent cases mean anything, they leave debatable issues as respects business, economic, and social affairs to legislative decision. We could strike down this law only if we returned to the philosophy of the Lochner, Coppage and Adkins cases."

The affidavits of plaintiff are far too generalized to justify the grant of summary judgment in their favor. Although the dissenting opinion alleges that plaintiff-hospitals "are compelled to operate at charges they contend are below the level of operating expenses . . . and that are . . . confiscatory," the affidavit of Mr. Armstrong in support of plaintiffs' Motion for Summary Judgment, at paragraph 6, objects to the failure of defendant to pay "the expenses incurred by the hospital in providing care to indigents, in writing off uncollectible accounts other than those of Blue Cross subscribers, in providing charity allowances, and in undertaking certain educational and research activities." Cf.

paragraoh 61 of supplemental affidavit of Bruce Taylor dated October 14, 1975. Defendant does not require plaintiffs to undertake such expenses, so that plaintiffs have failed to show that the expenses incurred by plaintiffs under Act No. 94 are the cause of the anticipated confiscatory effect of continuing operations under the Delaware Valley Agreement. The affidavits filed by plaintiffs fail to show with any specificity that the cause of their anticipated losses is Act No. 94, as opposed to their desire to provide service for their communities in accordance with the standards of the American Hospital Association (see, for example, page 18 of Plaintiffs' Memorandum, referring to the cost of "educational and research programs, credit losses, and the care of [indigent] patients. . .", and paragraph 15 of Mr. Armstrong's affidavit referring to "health care services required to maintain its accreditation" without making specific such generalities).

Plaintiffs' equal protection arguments are founded on the claim that Act No. 94 imposes burdens

only on member hospitals, leaving non-member hospitals unregulated. It is true that neither Act No. 94 nor the Hospital Plan Corporation Act regulates non-member hospitals. The obvious reason seems to be that the Hospital Plan Corporation Act regulates hospital plan corporations and those hospitals with whom they contract. As a result of the agreements between hospitals and hospital plan corporations, members of the general public enter into contractual agreements with the hospital plan corporation for the provision of health care benefits at member hospitals. Hospital plan corporations are required to receive certification from the Pennsylvania Insurance Department.[13] Hospitals which enter into agreements with hospital plan corporations likewise must be approved by the Department of Public Welfare.[14]

---

13. 40 Pa. C.S. § 6102.

14. 40 Pa. C.S. § 6121.

And, finally, contracts between hospital plan corporations and hospitals must receive Insurance Department approval.[15] Whereas member hospitals provide virtually total coverage for hospitalization and health care, and are reimbursed under the approved contract formula by Blue Cross, non-member hospitals receive full payment from subscribers, who are then only partially reimbursed by Blue Cross.

The determination of the legislature to regulate only member hospitals by Act No. 94 is not violative of equal protection. Under the equal protection clause, the test applied to any classification scheme set up by a state legislative body is whether the scheme has a rational basis.[16] The burden is on plaintiffs to show that the classifiaction scheme has no rational basis. Since non-member hospitals, by definition, have no contractual arrangement with Blue Cross, they were

---

15. 40 Pa. C.S. § 6124

16. See e.g., German Alliance Insurance Company v. Hale, 219 U.S. 307 (1911).

not included in a statute which regulates hospital plan corporations and, as incident to that regulation, hospitals with whom the corporations contract. In Nebbia v. New York, supra, appellant claimed that a New York statute authorizing establishment of minimum resale prices of milk for stores denied him equal protection because it enabled door-to-door distributors to provide additional services at an almost identical price. Specifically, the Milk Control Board had fixed the minimum price to be charged by a store and by a distributor for a quart of milk at nine and ten cents respectively. In its opinion, the Supreme Court stated: "But if it were shown that the appellant is compelled to buy [from a wholesale distributor and not directly from a farmer] the difference in the retail price he is required to charge his customers, from that prescribed for sales by distributors, is not on its face arbitrary or unreasonable, for there are obvious distinctions between the two sorts of merchants which may well justify a difference of treatment, if the legislature possesses the power

to control the prices to be charged for fluid milk." Id. at 521. Because of the substantial difference in subscriber benefits provided by member and non-member hospitals here, it cannot be gainsaid that the statutory distinction has no reasonable basis.

The foregoing shall constitute the findings and conclusions of the court on the plaintiffs' motion for injunctive relief, and such motion will be denied. The joint motions of defendants Blue Cross, Fitzpatrick, Kane and the Insurance Department for summary judgment will be granted, and the motions of plaintiffs for summary judgment will be denied.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PAUL I. GUEST President of Methodist Hospital; CHARLES H. FRENZEL, Executive Vice President of Mercy Catholic Medical Center; PHILIP J. SAWLINSKY, Manager of Patient Accounts of ST. JOSEPH'S HOSPITAL; and METHODIST HOSPITAL, on behalf of themselves and all others similarly situated	:	CIVIL ACTION
v.		
EMMETT F. FITZPATRICK,Jr. District Attorney of Philadelphia ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, Individually and in their Official Capacities, and BLUE CROSS OF GREATER PHILADELPHIA	:	No. 75-2306

O R D E R

The motion of Plaintiffs for summary Judgment is DENIED.

The motion of defendants for summary judgment is hereby GRANTED.

IT IS SO ORDERED.

FRANCIS L. VAN DUSEN

CHARLES R. WEINER

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PAUL I. GUEST, et al :

v. : CIVIL ACTION NO. 75-2306

F. EMMETT FITZPATRICK, et al :

LUONGO, J., dissenting

I agree that this is a matter which affects the health and welfare of the citizens of Pennsylvania. I agree also that the aim of this legislation -- to protect the ultimate consumers' need for continued hospital plan protection -- is commendable and is certainly within the police power of the state. In my view, however, the legislation missess the constitutional mark when it requires the hospitals to remain parties to the contract beyond the bargained for notice period without making some provision to compensate them for the losses they may incur during the period of enforced adherence to the terms of the last negotiated contract. Act 94 works an impermissible impairment of contractual obligations

in violation of the Contract Clause of the Constitution, and amounts to a taking of property without just compensation in violation of the Fourteenth Amendment to the Constitution.

The constitutionally offensive aspect of Act 94 is its retrospective effect. The act, passed August 2, 1975, applies to any contract then in effect between a member hospital and a hospital plan corporation, or any contract "under which subscribers received prepaid benefits on or after June 30, 1974.... Such contracts, if terminated, shall be reinstated as of their original termination and may be terminated hereafter only pursuant to the provisions of this act." 40 P.S. § 6124(c)2(2). Since the contracts, entered into in 1971, and amended in 1972, contain run-out provisions requiring payment for hospital services rendered after the termination date to subscribers who had been admitted prior to termination, the Act covers contracts which had, in fact, terminated prior to June 30, 1974. Undoubtedly

a state may constitutionally enact legislation imposing conditions on the termination of contracts entered into subsequent to the passage of the legislation, but the state oversteps the bounds when it imposes such conditions upon contracts entered into prior to the adoption of the legislation without providing some measure of protection against loss to the party affected.

Act 94 requires hospitals and the various hopsital plan corporation, including Blue Cross, to continue to adhere to the terms of their last negotiated contract for approximately a year beyond the termination date provided in the contract. The effect of the Act is to force contracting hospitals to continue to provide care to subscriber patients at increasing current costs, while reimbursement from the hospital plan corporations is based on previously negotiated cost calculations and formulae which the hospitals claim is insufficient to reimburse them for their expenses.

The cost formulae adopted in the earlier negotiated contracts do not allow to the hospitals, as reimbursable expenses, most community service activities, including care provided to indigents, writing off uncollectible accounts of patients not insured under a contracting hospital plan corporation, providing charity allowances, and undertaking certain education and research activities. Private paying patients or patients with private insurers have, accordingly, always paid a disproportionate share of such expenses. In earlier years there apparently existed sufficient numbers of such patients, and the hopsital plan corporation arrangement had sufficient advantages, to make it financially feasible for the hospitals to enter into such agreements. Under the present arrangement, more individuals will likely become subscriber patients because of the relatively lower premiums the hospital plan corporations can charge, since under Act 94 the hospital plan corporations will pay to the hospitals less than private insurers or self-paying patients will be required to

pay. Thus an increasingly higher percentage of the hospitals' patients will not be paying their share of the cost of the hospitals' community service activities. Moreover, subscriber patients will be paying for hospital services, through the hospital plan corporation, rates which do not fully reflect the escalating costs caused by the inflationary spiral. The contracting hospitals have thus been forced by the state into furnishing services at charges lower than their actual expenses of furnishing such services. True, the Act does provide that if a new contract is negotiated during the extension period, "the terms and conditions of any new contract shall be retroactive to the date of expiration of the contract previously in effect between the parties." If a new contract is negotiated between the parties, it would presumably make allowance, satisfactory to the hospitals, for the hospitals' costs of operation. There is no assurance, however, that a new contract which will fairly compensate the hospitals for their costs, will be negotiated and entered into, and no provision

is made to compensate the hospitals for their losses incurred in the interim period if no new contract is negotiated.

Act 94 clearly has the effect of modifying the contracts that existed between member hospitals and Blue Cross. The majority does not dispute the modifying effect, but finds that the public interest of preserving the health of Pennsylvania citizens justifies the measure. It is true that where the public welfare requires, the state may use its police power in a manner which, to some degree, impairs the obligations of existing contracts, but the states' power to do so is limited. Here the effective excision of the termination clause from the contract is too substantial an impairment, I believe, to be constitutionally permissible. Both parties to the contract bargained for benefits and burdens they were willing to accept and assume for a certain period of time, subject to their right to terminate at the end of the stated period upon giving 90 days' notice. The excision of that termination provision has the

effect of forcing the hospitals to provide, beyond the agreed period, services at charges the hospitals now claim to be below operating cost level, and which are therefore confiscatory.[1]

No matter how great the public need, the state may not, without violating the Fourteenth Amendment, take property without just compensation. The due process and impairment of contract claims are not readily separable, and an impairment claim will usually give rise to a due process claim. See Fornaris v. Ridge Tool Co., 423 F.2d 563, 566-67 (1st Cir. 1970), rev'd on other grounds, 400 U.S.41 (1971). In the present suit, there is concededly an impairment. I believe the impairment to be so substantial as to violate the Contract Clause, and in any case the impairment works a taking of property without due process of law. The case authority not to the contrary.

- -

1. The affidavits of Messrs. Armstrong, Guest, and Williamson may not be sufficient to establish that the imposed rates are confiscatory, but at the very least they raise a material issue of fact for trial.

In Home Building & Loan Association v. Blaisdell, 290 U.S. 398 (1934), the Supreme Court upheld a state statute which retroactively extended the period during which a defaulting mortgagor could redeem property which had been foreclosed. Although the contract rights of the parties were altered, the Court found the statute constitutionally sound because the substantive rights of the parties were not impaired:

> "The statute does not impair the integrity of the mortgage indebtedness. The obligation for interest remains. The statute does not affect the validity of the sale or the right of a mortgagee-purchaser to title in fee, or his right to obtain a deficiency judgment, if the mortgagor fails to redeem within the prescribed period. Aside from the extension of time, the other conditions of redemption are unaltered. While the mortgagor remains in possession he must pay the rental value as that value has been determined, upon notice and hearing, by the court. The rental value so paid is devoted to the carrying of the property by the application of the required payments to taxes, insurance and interest on the mortgage indebtedness. While the mortgagee-purchaser is debarred from actual possession, he has, so far as rental value is concerned, the equivalent of possession during the extended period." (Emphasis supplied)

290 U.S. at 425

Where legislation has been applied retroactively and has altered the substantive contractual rights of the parties, the Supreme Court has invalidated it. In Louisville Joint Stock Land Bank v. Radford, 295 U.S. 555 (1935), the Court struck down the Frazier-Lemke Act, a federal law which permitted mortgagors to redeem property at its appraised value, regardless of the amount of the outstanding debt. The Court held that the forced surrender of possession and title to property, so long as any part of the debt secured thereby remained unpaid, effected a taking of property without just compensation and could not be justified, however great the public need. The Court distinguished Blaisdell, supra, on the ground that in Blaisdell no substantive right had been abridged. Id. at 581. W. B. Worthen Co. v. Kavanaugh, 295 U.S. 56 (1935), reaches the same conclusion. In that case the Supreme Court struct down a state statute extending the period of redemption on grounds it violated the Contract Clause. Again the Court found that the substantive rights of the parties

had been altered by the legislation in that the mortgagor was permitted to retain possession of the property without the payment of interest, taxes or rent. In the instant suit, the state has substantially extended the period of the contract and has thereby imposed terms on the hospitals which they claim make it impossible for them to meet their expenses without dipping into reserves. This clearly places the case in line with Radford and Worthen, and not Blaisdell.

Day-Brite Lighting, Inc. v. Missouri, 342 U.S. 421 (1952), is as readily distinguishable as Blaisdell. That case involved a state statute which permitted employees to absent themselves from work for several hours, without loss of pay, to vote. In upholding the constitutionality of such legislation, the Supreme Court spoke only of the permissibility of state regulations which impose financial burdens upon, and reduce "the net return" from business enterprises. That is a far cry from the plight of these non profit hospitals which content they are being required to operate at inadequate and confiscatory levels of

reimbursement.

Even if this were regarded as a "rate" case, which I think it clearly is not, "[a]s of right safeguarded by the due process clause of the Fifth Amendment, [the regulated entity] is entitled to rates, not per se excessive and extortionate, sufficient to yield a reasonable rate of return upon the value of property used, at the time it is being used, to render the services." Denver Union Stock Yard Co. v. United States, 304 U.S. 470, 475 (1938). A fully regulated utility cannot be compelled to absorb its own costs and not pass them on to the consumer. Public Service Commission v. Federal Power Commission, 467 F. 2d 361, 370 (D.C. Cir. 1972). Even temporary rates which are confiscatory are not permissible. Prendergast v. New York Telephone Co., 262 U.S. 43, 49 (1923). Cf. Beaver Valley Water Co. v. Driscoll, 28 F Supp. 722 (W.D. Pa. 1939).

In the case perhaps most nearly on point, the Court of Appeals for the First Circuit held unconstitutional, as applied to contracts entered into before

its passage, a Puertan law which prohibited a manufacturer from terminating a dealership contract unless justified by a substantial failure of performance by the dealer. Fornaris v. Ridge Tool Co., 423 F. 2d 563 (1st Cir. 1970), rev'd on other grounds, 400 U.S. 41 (1971). Chief Judge Aldrich based the decision on the Fifth[2] Amendment Due Process Clause, stating that it was unnecessary to deal with the impairment of contracts issue "because the due process clause of the federal constitution provides essentially the same restraint so far as retrospectivity is concerned." He noted that "[i]n determining whether retroactive alteration of contractual provisions are sufficiently minor to be permissible a distinction is sometimes drawn between alteration of substantive rights and alteration of procedures or remedies," and that "[n]o amount of research by parties or amici has discovered a case

---

2. The Fifth, rather than the Fourteenth, Amendment because Puerto Rico is not a state. See generally, discussion in footnotes 7 and 8, id. at 566-67.

suggesting that..."a statute converting a contractual relationship from one terminable without cause to terminable only for just cause was not one that worked "a change of great magniture." Id. at 567-68 (footnoted omitted). A similar state statute modifying manufacturers' termination rights under franchise agreement was held unconstitutional, this time on the basis of the Contract Clause, in Superior Motors, Inc. v. Winnegabo Industries, Inc. , 359 F. Supp. 773 (D. S.C. 1973). In my view, the statute in the present case is more egregious then those in Fornaris and Superior Motors since it prohibits termination altogether during the period of extension.

The Contract Clause is not an absolute barrier to state legislative enactments which have the effect of modifying existing contracts, and there is no question but that a state may regulate enterprises affecting the public interest, but the Constitution sets limits to the manner and degree in which the state may exercise its police power. In the present instance, the failure of the contracting parties to

come to an agreement has resulted in an unfortunately hasty reaction by Pennsylvania legislature which, I believe, exceeds those limits by failing to make provision to protect the hospitals against loss during the period of extension.

Accordingly, I respectfully dissent.

Supreme Court, U. S.
FILED
NOV 13 1976
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

October Term, 1976

No. 75-1691

PAUL I. GUEST, ET AL.,

Appellants

v.

F. EMMETT FITZPATRICK, JR., ET AL.,

Appellees

No. 75-1698

THE WILLIAMSPORT HOSPITAL, ET AL.,

Appellants

v.

F. EMMETT FITZPATRICK, JR., ET AL.,

Appellees

On Appeal from the District Court for the Eastern District of Pennsylvania

Brief for Appellants at No. 75-1698

Nauman, Smith, Shissler & Hall
JAMES H. STEWART, JR.
SPENCER G. HALL, JR.
Six North Third Street
Bergner Building, P. O. Box 840
Harrisburg, Pennsylvania 17108

Counsel for The Williamsport Hospital and The Hospital Association of Pennsylvania

INDEX

Page

OPINIONS BELOW 1

JURISDICTION 1

STATUTES, RULES, AND REGULATIONS INVOLVED 2

QUESTIONS PRESENTED 2

STATEMENT 2

SUMMARY OF ARGUMENT 5

ARGUMENT 6

I. A state may not, by statute, require the sale of private hospital services to a private insurer at less than their real cost, including costs of community services for charity patients, bad debts, research, and for operating growth needs 6

II. Act No. 94 of 1975, unconstitutionally takes Appellants' property without just compensation in violation of the Fourteenth Amendment to the United States Constitution by requiring sale of appellants' services below their real cost 12

III. Hospitals are not a rate regulated industry 16

A. Regulation of Pennsylvania Hospitals 16

B. Travelers is distinguishable and in error 19

CONCLUSION 22

TABLE OF CITATIONS 24

IN THE

Supreme Court of the United States

October Term, 1976

No. 75-1691

PAUL I. GUEST, ET AL.,

Appellants

v.

F. EMMETT FITZPATRICK, JR., ET AL.,

Appellees

No. 75-1698

THE WILLIAMSPORT HOSPITAL, ET AL.,

Appellants

v.

F. EMMETT FITZPATRICK, JR., ET AL.,

Appellees

BRIEF FOR APPELLANTS

OPINION BELOW

The opinion and order of the District Court for the Eastern District of Pennsylvania were rendered on February 27, 1976, and are reported at 409 F. Supp. 818 (E.D. Pa. 1976).

JURISDICTION

The order of District Court was entered on February 27, 1976. The Notice of Appeal to this Court was filed in the United States District Court for the Eastern District of Pennsylvania on March 24, 1976. The Jurisdictional Statement was filed in this Court on March 24, 1976, and this Court noted probable jurisdiction on October 4, 1976.

The jurisdiction of this Court is predicated upon 28 U.S.C. §1253.

STATUTES INVOLVED

The statute of the Commonwealth of Pennsylvania herein involved is the Act of August 2, 1974, Act No. 94, 40 Pa. C.S. §6124, et seq., which statute is reproduced in its entirety at page 1 of the Appellants' Jurisdictional Statement Appendix.

QUESTIONS PRESENTED

1. May a state, by statute, require the sale of private hospital services to a private insurer at less than their real cost including costs of community services for charity patients, bad debts, research, and for operating growth needs?

2. Does Act No. 94 of 1974, by requiring sale of hospital services below real cost, unconstitutionally take Appellants' property without just compensation in violation of the Fourteenth Amendment to the United States Constitution?

3. Are hospitals, as opposed to hospital plan corporations, rate regulated industries?

STATEMENT

The Williamsport Hospital and other hospitals represented by The Hospital Association of Pennsylvania are affected by Act No. 94 only by the loss of the right to terminate their Blue Cross contracts on ninety (90) days notice.[1]

---

1. Appellants in No. 75–1698 concur in the arguments presented by Appellant to No. 75–1691 and rely upon the issues there presented. In view of the consolidation, we have limited our brief to the issues of confiscation, taking of property without compensation, and the Lower Court's misreliance on *Travelers Insurance Company* v. *Blue Cross of Western Pennsylvania*, 361 F. Supp. 774 (W.D. Pa. 1972), aff'd. 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1974).

Act No. 94 has ingrained upon their contracts a period for termination which may take as long as thirteen months, and thus since these contracts, like the Philadelphia contract, are based upon the reasonable cost reimbursement system under the Medicare regulations with various modifications, the thirteen months' extension forces hospitals to receive reimbursement at a lower level than they could receive if they were able to terminate the contract and initiate direct billing to each patient.

Much more important than the time for termination is the effect of this statute in imposing state requirements to continue to serve Blue Cross subscribers at less than the real cost of hospital care. For a variety of reasons, hospitals have been forced to agree to reimbursement from Blue Cross which fails to include their fair share of the cost of community service performed by hospitals.

Hospitals serve four segments of patients which provide revenues which may vary by hospital, but are roughly equal in size. These are Medicare patients, Medicaid patients, Blue Cross subscribers, and self-pay patients. Self-pay patients include those with commercial insurers, and those who pay only part of their bills. Hospital charges are paid only by self-pay patients, and are substantially higher than levels of cost reimbursement for the same services paid by Blue Cross on behalf of its subscriber, sometimes by as much as 40 percent higher. The other three segments pay "reasonable cost" reimbursement as determined under the Medicare formula with some modifications.

In addition to those contributing to hospital revenues, there are patients, treated as charity patients, who make no payments at all, and patients who are not identified as charity patients on admission but who are unable to pay all of their hospital bills and thus become "bad debts". Likewise, under-compensation for ambulatory care under the Medicaid program appears as charity care to the extent of the cost over state reimbursement. These community service costs to hospitals are part of the "real cost" of

operating a hospital, and the record in this case shows that these costs are causing substantial losses in operating most hospitals. Most hospitals are covering these costs by spending their allowance for depreciation to cover the deficit (Williamson Affidavit paragraph 7), while philanthropy, which historically was available as a source to offset losses, has long since been insufficient to cover the costs for community services of hospitals.

Blue Cross, under its subscriber agreements, contracts to provide medical insurance to its subscriber which insurance will cover all, with minor exceptions, costs incurred by a subscriber in receiving health care if the subscriber selects a member hospital. In the event that a subscriber fails to go to a member hospital, Blue Cross only provides benefits at a rate unrelated to the premium that the subscriber paid for the coverage. Typically, Blue Cross will only provide benefits up to $50 per day for the first day of hospitalization and $25 per day thereafter if the patient selects a nonmember hospital. Act No. 94 purports to remedy, under the guise of protecting the health and welfare of Pennsylvania citizens, a crisis in the health industry, which crisis would result if Blue Cross subscribers were unable to receive treatment at member hospitals. This alleged crisis, addressed by Act No. 94, resulted not from the hospitals' refusing to contract with Blue Cross, but rather from Blue Cross' refusal to provide reasonable benefits to its subscribers who received care from a nonmember hospital. If Blue Cross would provide benefits at a nonmember hospital equivalent or nearly equivalent to the pay-out of benefits at a member hospital, this crisis would not have resulted.

Blue Cross sells term insurance to its subscribers, and in its contracts with member hospitals provides that if the contract between the member hospital and Blue Cross is terminated, then a run-out period commences which protects the Blue Cross subscriber who has purchased term insurance which remains in effect. Essentially, the run-out provision guarantees to the Blue Cross subscriber that he

may select the services of a former member hospital even though Blue Cross and the hospital have terminated their contract. It is important to note, that the subscriber, in contracting with Blue Cross, has not prepaid for further coverage at a member hospital after the anniversary date of his policy. If a subscriber renewed with Blue Cross after August of 1974, it was with the full knowledge that the Blue Cross contract with their hospital had been terminated and that the subscriber was only entitled to receive those benefits payable at a nonmember hospital. Accordingly, the statutory declaration contained in Act No. 94 that Blue Cross insurance is prepaid is not supported by the record, nor is it an accurate understanding of the way in which Blue Cross contracts operate.

Finally, it is Appellant's position that since there was no state anti-trust regulation of Blue Cross until the Act of July 22, 1974, P.L. 31, 40 Pa. C.S.A. §1171.1, et. seq., which Act postdates the contracts in question, hospitals are not regulated under Pennsylvania law. Rates of payment from Blue Cross are not subject to rate regulation but only to Insurance Department approval and thus the refusal to permit hospitals the real cost of rendering care cannot be justified as part of a system of rate regulation. Accordingly, Act No. 94 cannot be justified as filling the gaps in a regulatory scheme, which does not exist.

SUMMARY OF ARGUMENT

The Medicare "reasonable cost" reimbursement formula which pays only for patients within the program in "taking care of their own" is partially justified for Medicare and Medicaid but is inappropriate for Blue Cross. Medicare includes all over 65 years of age and Medicaid pays for indigents. Blue Cross subscribers are the bulk and the backbone of the economy of the community. Community services rendered by hospitals should be paid proportionately by Blue Cross subscribers as a matter of public policy.

Care is required for those unable to pay not covered by the state determined levels for Medicaid and for those able only to partially pay—"bad debts". This care is most of the community service of hospitals. The cost of this care is a "real cost" of operating a hospital. If "real cost" is accepted as cost, Act No. 94 requires hospitals to operate at less than cost if no contract is finally agreed upon.

A state requirement to operate at less than cost is a taking of property without just compensation in violation of the Fourteenth Amendment of the Constitution of the United States.

The loss of the right to terminate a Blue Cross contract by a member hospital as provided in Act No. 94 of 1975 which results in a confiscatory taking of its property, is a loss of a substantive contractual right which violates the Contract Clause.

Act No. 94 violates both of these Constitutional provisions and the order of the lower court should be reversed.

ARGUMENT

I. A STATE MAY NOT, BY STATUTE, REQUIRE THE SALE OF PRIVATE HOSPITAL SERVICES TO A PRIVATE INSURER AT LESS THAN THEIR REAL COST, INCLUDING COSTS OF COMMUNITY SERVICES FOR CHARITY PATIENTS, BAD DEBTS, RESEARCH, AND FOR OPERATING GROWTH NEEDS.

Although not specifically addressed by the Lower Court, a resolution of the underlying issue that a hospital is entitled to receive reimbursement at a level to meet its real cost of hospital care is imperative to sustain Appellants' position that Act No. 94 is confiscatory and thus takes property without due process of law.

Ninety-five percent of the hospitals in Pennsylvania and most hospitals across the nation are nonprofit institutions. These hospitals originally were operated as purely charitable institutions catering to the indigent and medically indigent. Historically, hospital revenues were derived

from contributions made by local taxing authorities in the areas in which they resided, endowment income, and a small charge to those who were able to pay. This charge never approximated the actual cost to the hospital of providing its services. *Factors Affecting the Costs of Hospital Care,* edited by John H. Hayes.

Increasingly throughout the twentieth century, hospitals have been recognized as the most appropriate places in which to receive quality medical care. While in earlier times, persons able to pay for medical care received it in their private homes and not in hospitals; today, such practice is obsolete. As the patient load increased and the commensurate advances in medical science and its expansive technology flourished, the original financing sources supporting hospitals have become clearly inadequate. No longer can hospitals rely on the largesse of public and private benefactors supplemented by a charge to patients unrelated to actual cost, if they are to provide high quality care to their patients, and operate in a fiscally sound manner.

During the depression years of the 1930s, a development related to the financing of hospital care occurred with the enactment of the Hospital Plan Corporation Act of 1937, Act of June 21, 1937, P. L. 1948, in Pennsylvania. This Act provided for Blue Cross corporations to provide term insurance for their subscribers to meet the costs of health care and the medical necessity of receiving treatment in hospitals as opposed to private homes. Due to the depression and the inability of persons to financially meet the burdens of health care, Blue Cross was started to provide a community fund from which those in need of medical care could receive that care, and the expense would be spread over a large number of persons.

Initially, when Blue Cross first began, the numbers of persons insured by Blue Cross did not approach its current 50 percent control of the market in Philadelphia. Accordingly, when hospitals agreed to provide preferential treatment to Blue Cross subscribers for the guarantee of

prompt payment, the hospitals were able to give that preferential treatment to Blue Cross subscribers for the guarantee of prompt payment. The hospitals were able to give that preferential treatment while knowing that their costs for bad debts, charity care, and expansion could be spread over the larger number of private-pay patients. A relatively minor increase in costs to the majority of private-pay patients insured that a hospital could receive its actual costs. Even at this earlier time, private-pay patients were subsidizing Blue Cross subscribers.

As Blue Cross' percentage of the prepaid insurance market has increased, there has been a commensurate decrease of the number of persons upon whom a hospital can reasonably expect to shift the burden of paying the hospital its full financial requirements. This development means that whereas, historically it was the responsibility of the entire community to provide the real costs of a hospital through contributions from taxing authorities and endowment income, that community, because Blue Cross provides insurance for the vast majority of the patients, has grown smaller and smaller over the years. Since local taxing authorities and philanthropy no longer provide the substantial contributions required to support a hospital in fulfilling the community responsibility to insure the availability of care to all, the community responsibility must be borne by all those able to pay receiving health care. This manifestly includes Blue Cross subscribers who are members of the community which the hospital serves.

Approximately 75 percent of all hospital services in Pennsylvania, including Blue Cross reimbursement, is based upon a "reasonable cost" reimbursement formula as modified by contract. This reimbursement is predicated upon the statutory theory created in the Medicare program, 42 U.S.C.A. 1395X(v)(1)(A), which provides for reimbursement at reasonable cost. Reasonable cost includes actual cost, excluding any part of incurred cost found to be unnecessary. The regulations are required to provide that ". . . necessary cost of efficiently delivering covered services

to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered and the costs with respect to individuals not so covered will not be borne by such insurance programs. . . ."

This theory of "taking care only of your own" may be appropriate both for Medicare and Medicaid, but is wholly inappropriate for Blue Cross, particularly in a place like Philadelphia, where more than 50 percent of the population are Blue Cross members. This represents a much higher percentage of those able to pay for medical care.

Only 25 percent of all patients pay hospital charges. The rest are covered by Medicare, Medicaid, or Blue Cross. Since the latter three pay only reasonable cost under the Medicare formula, any cost not paid as part of allowable reasonable cost has fallen upon self-paying patients or their commercial insurers who must pay hospital charges. This burden has grown as each organized cost reimbursement program has tightened its rules, so that some hospital charges, to this limited group of private-pay patients, are as much as 40 percent more than cost reimbursement.

Some of the real costs of operating a hospital that are not recognized in the "take care of your own" theory of cost reimbursement are charity patients, bad debts, and the operating growth needs of hospitals. Charity patients are those not eligible for medical assistance who still cannot afford to pay hospital bills. Bad debts arise largely from those who cannot be identified as charity patients on admission who still find it impossible to pay all of their bills. These persons are treated at hospitals as part of their tradition of rendering medical service to those who require help without regard to ability to pay.

This community service, the Lower Court found, was not imposed upon hospitals by Blue Cross patients, with which for the most part we can agree. There is likewise a Hill-Burton[1] commitment by most hospitals to perform such service, but Hill-Burton moneys are invested in bricks

1. 242 U.S.C.A. 291, et seq.

and mortar. There is no commitment by hospitals not to recoup the costs of such service from their patients as part of the real cost of operating the hospital.

Medicare largely takes care of both rich and poor over 65 years of age, and the statutory policy of "taking care of their own" can be at best partially justified on this basis. The throwing off of costs for misutilization or expiration of entitlements under this program burdens other individuals in contradiction of the statutory policy. So will the new cost limits permitted under the most recent amendment of the Medicare Act (October 30, 1972 92–603), but at least to this point these burdens have been bearable.

Medicaid provides for a state-determined class of indigents, if not all those needing medical assistance. It is difficult to argue that this relief program should be burdened by the costs of those for whom the legislature failed to perceive the need. This program likewise throws off costs of misutilization, and until recently expiration of entitlement[2], which must be borne by individuals not covered by Medicaid, but this burden too has to date been found bearable.

It is Blue Cross, with its enrollment of the great bulk of the population able to pay for hospital services, which by adopting the Medicare approach has avoided for its subscribers their fair share of the community services of the hospital. Many Blue Cross subscribers, as group participants, have their premiums paid as fringe benefits by their employers. It is this broad base of Blue Cross members from whom the cost of bearing their fair share of community services must be collected if hospitals are to survive and continue to render service in accordance with the community needs.

Although we have talked of roughly a quarter of the patient population in hospitals being Blue Cross sub-

2. The Act of July 15, 1976 P.L.–(No. 202) amended the Public Welfare Code Act of June 13, 1967, P.L. 31 Article IV §443.1, 62 P.S. 443.1 to eliminate the sixty day benefit period limitation.

scribers and a quarter being self-pay patients, in Philadelphia more than half of the population are subscribers whether in need of hospital services or not and the self-pay patients include all those who turn out to be bad debts.

It becomes a matter of public policy whether by seeking the shield of Blue Cross membership one can shirk the community responsibility of paying for care for the less fortunate. The record in this case discloses that some Pennsylvania Insurance Commissioners, in a misguided attempt to keep Blue Cross subscriber rates down, have opposed "their own" bearing their fair share of these costs. They have eliminated this portion of the real cost of operating a hospital by simply having these costs negotiated as "not allowable" in determining "reasonable costs" by following the Medicare formula.

The ability to persuade Blue Cross to exclude these costs is a far cry from imposing a rate system, or prohibiting the termination of the contract, by state action which requires the hospital to render service at less than their real cost. This is doubly important in hospital financing where half of the revenues are based upon reimbursement at less than real cost in "taking care of their own" for Medicare and Medicaid.

If all segments of the hospital population paid only for "their own", some people would have to go without hospital care. The Court Below seemed to feel this was not at issue in this case. Only by ignoring the need for payment of the real cost of operating hospitals including its community service could the Lower Court ignore the confiscatory aspect of retroactive application of Act No. 94.

The statement of the Lower Court that Blue Cross does not require hospitals to undertake community services and that such services are rendered to meet the standards of the American Hospital Association (No. 75–1698 J.S. p. A21) is to ignore the community need for such services. Blue Cross having captured the great bulk of the community able to pay, cannot so easily shrug off the responsibilities of its subscribers.

This point is well stated by Luongo, J., in his dissenting opinion 409 F. Supp. 818. 828 (1976):

> "The cost formulae adopted in the earlier negotiated contracts do not allow to the hospitals, as reimbursable expenses, most community service activities, including care provided to indigents, writing off uncollectible accounts of patients not insured under a contracting hospital plan corporation, providing charity allowances, and undertaking certain education and research activities. Private paying patients or patients with private insurers have, accordingly, always paid a disproportionate share of such expenses. In earlier years there apparently existed sufficient numbers of such patients, and the hospital plan corporation arrangement had sufficient advantages, to make it financially feasible for the hospitals to enter into such agreements. Under the present arrangement, more individuals will likely become subscriber patients because of the relatively lower premiums the hospital plan corporations can charge, since under Act 94 the hospital plan corporations will pay to the hospitals less than private insurers or self-paying patients will be required to pay. Thus an increasingly higher percentage of the hospitals' patients will not be paying their share of the cost of the hospitals' community service activities."

It is respectfully submitted that Act No. 94 by imposing the Medicare formula on hospitals for a period of thirteen months through state action, is confiscatory in that it fails to return to hospitals the proportionate real cost of operating their institutions. If no contract is finally negotiated, this loss is irrevocable for the hospital.

II. ACT NO. 94 OF 1975, UNCONSTITUTIONALLY TAKES APPELLANTS' PROPERTY WITHOUT JUST COMPENSATION IN VIOLATION OF THE FOURTEENTH AMENDMENT TO THE UNITED STATES CONSTITUTION BY REQUIRING SALE OF APPELLANTS' SERVICES BELOW THEIR REAL COST.

Act No. 94, in Section 2 thereof, retroactively reinstates terminated contracts between Hospital Plan Corpo-

rations and contracting hospitals and prohibits hospitals with existing contracts from terminating them in accordance with their terms. Upon reinstatement or upon a desire to terminate, the provisions of Section 1 of the Act, which pertain to the procedure under which contracts may be terminated, become applicable to the contracts.

Section 1 of the Act requires that in order for a contract to be terminated, the parties must provide each other and the Department of Insurance with ninety days' advance written notice. The Insurance Commissioner must then hold public hearings to investigate the termination and, incident thereto, the contract termination is then suspended for up to six months. Following the hearings, the Commissioner makes specific findings as to the dispute and makes recommendations for further negotiations between the parties.

After the Commissioner makes his recommendations, the Act requires the parties to renew negotiations and, incident thereto, the terminated contract is extended an additional period of ninety days. In the event that a settlement is then reached by the parties, the new contract, pursuant to Section 1(a)(5) of the Act, is automatically made retroactive to the date of expiration of the contract previously in effect between the parties.

It is important to note that Act No. 94 does not purport to give the Commissioner the power to impose a contract on the parties. The Commissioner's power is solely to hold hearings and make recommendations. It is true that the Commissioner must approve the contract and the rates agreed to by the parties, 40 Pa. C.S. §6124, but clearly his role is limited, for though he may refuse to approve the contract and thus the negotiated rates contained therein, he may not impose others to his satisfaction.

Secondly, while the Act provides that any negotiated contract shall be retroactive—hospitals thus would not lose any contract benefits by virtue of the extensions to the preexisting contract under the Act—it fails to provide a mechanism for the hospitals to recoup their loss in the event that

a new contract is not negotiated. The burden of absorbing the difference between the hospitals' real costs and the rate of payment under the pre-existing contract, during the statutory extensions, therefore, would be borne only by the hospital which would not have any recourse against the Hospital Plan Corporation. The statutory extensions of the contract and the failure to provide a mechanism for hospitals to receive their real costs, if a new contract is not negotiated, deprive hospitals of their property without just compensation.

Prospectively, the statute is constitutional but it cannot properly be applied to reinstate contracts or to contracts presently in existence.

The Philadelphia contracts were specifically terminated by area hospitals because the Appellee refused to include the real cost of rendering hospital care in their formulas, and the hospitals felt they could no longer continue to operate under a reimbursement formula that failed to include these costs. As the result of the reinstatement, by Act No. 94, of these terminated contracts, hospitals continue to suffer the loss of necessary revenues essential to their fiscal stability, which revenues would not be lost, but for Act No. 94 because the hospitals would be directly billing subscribers. It is not a question of reducing the net rate of return to a profit-making institution, but rather causing the hospital to operate at a loss.

Without conceding that hospitals are a regulated industry, an issue which will be addressed later, this Court's decision, relevant to the right of regulated industries to receive a "reasonable rate of return", and the right of a regulated business not to operate at a loss, are instructive. This Court has uniformly held that an unreasonably low rate of return is confiscatory and violative of due process. *Denver Union Stock Yard Co.* v. *U.S.*, 304 U.S. 470 (1938); *U.S. Rys & Elec. Co.* v. *West*, 280 U.S. 234 (1930); See also, *D.C. Transit System, Inc.* v. *Washington Metropolitan Area Transit Commn.*, 466 F.2d 394 (D.C. Cir. 1972), *cert. den.*, 409 U.S. 1086 (1972).

Although decided under the Contract Clause, Article I, Section 10, of the Constitution, the cases of *W. B. Worthers Co.* v. *Kavanaugh*, 295 U.S. 56 (1935); *Home Building & Loan Assoc.* v. *Blaisdell*, 290 U.S. 398 (1934); and *Louisville Joint Stock Land Bank* v. *Radford*, 295 U.S. 555 (1935), are also instructive as to the constitutional parameters within which the legislature or Congress may enact retrospective statutes.

In both *Kavanaugh and Blaisdell*, this Court construed statutes which retroactively extended the period during which a defaulting mortgagor could redeem property upon which the mortgagee had foreclosed. In sustaining the constitutionality of a Minnesota statute, this Court noted in *Blaisdell* that though the mortgagee was denied physical possession of the premises, it retained, because the mortgagor was required to pay a fair rental to the mortgagee, "the equivalent of possession during the extended period", 398 U.S. at 425. Additionally, the mortgagee was not required to forfeit any deficiency judgment in the event the property was redeemed; and finally, the extension was for a limited period of time. The substantive rights of mortgagees were not impaired in light of the above provisions.

A state statute somewhat similar to that sustained in *Blaisdell*, in that it also extended the redemption period for defaulting mortgagors, was struck down as violative of the contract clause in *Kavanaugh* because that statute effected the substantive rights of the mortgagees. Unlike the provisions of the Minnesota statute sustained in *Blaisdell*, the statute in *Kavanaugh* failed to protect the mortgagee, the defaulting mortgagor was not required to pay rent while he remained in possession, nor was the mortgagor responsible for interest or taxes. The resulting infringement of the mortgagee's rights was substantive as they had to assume the financial burden of the state's largesse.

This Court similarly concluded in *Radford* that a federal law, the Frazier-Lemke Act, failed to pass constitutional muster because it permitted defaulting mortgagors to redeem property at its appraised value regardless

of the amount of the outstanding debt. The substantive rights of mortgagees were impaired, and thus, the statute effectuated a taking of property without just compensation. The demonstrably great public need could not justify this constitutional abridgement.

The confiscatory result of Act No. 94 is analogous to the statutes in question in *Kavanaugh* and *Radford* because the substantive contractual right of a hospital to terminate its contract with Blue Cross, and thus obtain relief from necessary reimbursement below its full financial requirements is impaired without the statute providing for financial relief to hospitals in the event a new contract is not consummated. This result is violative of the Fourteenth Amendment in that a hospital's property, re the services it renders to a patient, is being taken without just compensation. Such a result cannot be condoned on the basis of public policy or on the basis that hospitals are not regulated industries and the Appellants respectfully urge this Court to reverse the decision of the Lower Court.

III. HOSPITALS ARE NOT A RATE REGULATED INDUSTRY

The majority of the Lower Court, in its opinion, does not contend that property is not being taken without just compensation but rather, the majority opinion attempts to justify this taking by saying that hospitals are rate regulated corporations and thus, the state may impose remedial measures regarding the disputed rates, 409 F. Supp. at 825.

The assumption by the majority of the Lower Court that hospitals are rate regulated corporations is at the heart of this controversy and Appellants submit that such a conclusion is emphatically wrong.

A. REGULATION OF PENNSYLVANIA HOSPITALS

Hospitals in Pennsylvania have been subject to supervision by the Department of Welfare for many years, under the Public Welfare Code as first enacted, Act of April 9,

1929, P.L. 177, and codified by the Act of June 13, 1967, P.L. 31 (No. 21), Articles 9 and 10, 62 P.S. §901, et seq. Article 9 dealt with nonprofit hospitals which were defined as "supervised institutions" if they received aid either directly or indirectly from the state. Article 10 provided for licensing of proprietary institutions. Each provided for the creation of minimum standards for the care and treatment of patients and the management of patient conduct and provided a duty of visitation and right of inspection of these institutions to assure that the standards were being met. The authority was transferred as to hospitals under Reorganization Plan No. 2 of 1973, 71 P.S. §755-2, to place this authority in the Department of Health.

Despite the newspaper publicity which the recent Insurance Commissioner, Herbert Denenberg, obtained for his activities in the health care field, the only authority, before the passage of Act No. 94, that he had over hospitals was the approval of contracts between Blue Cross plans and hospitals under the Nonprofit Hospital Plan Act of June 21, 1937, P.L. 1948, now codified by 40 Pa. C.S.A. §6124(a). This Act gave him authority to approve or disapprove all rates of payments to hospitals by hospital plan corporations and all contracts entered into by Blue Cross with its member hospitals. Act No. 94 added to his authority the right to make recommendations and findings as to disputes between Blue Cross and its member hospitals in negotiating a contract, but even Act No. 94 failed to provide the Commissioner a right to set rates.

The regulatory power of the Department of Welfare, now in the Department of Health, certainly failed to make hospitals a regulated industry as that term is used to justify the conclusion of the Lower Court. Hospitals are no more regulated than are restaurants which are required to maintain certain minimal standards of cleanliness in purveying food to the public.

The regulatory power of the Insurance Commissioner is even more limited since the Nonprofit Hospital Plan Corporation Act, Act of November 15, 1972, P.L.—— (No.

271), 40 Pa. C.S.A. §6101, et seq., provides that approval of contracts is to be made in accordance with the procedure for approving certification of hospital plan corporations, 40 Pa. C.S.A. 6124(b), and that procedure, after empowering the Department to establish the form of applications for approval, provides 40 Pa. C.S.A. 6101(d) as the standard for issuance of a certificate of authority (approval) that it "shall be issued by the Department only if and when the Department shall find and determine that the application complies with the provisions of this Chapter and the regulations of the Department thereunder".

It is significant that the Insurance Department in Pennsylvania never promulgated rules for the application for, or approval of, Blue Cross contracts or with respect to the provisions to be contained in Blue Cross contracts with hospitals except for the informal guidelines which had no official status. There also is a provision under 40 Pa. C.S.A. 6102(e) for the Department in granting approval to impose such conditions as it may deem just and reasonable. These conditions, however, must conform to making the application comply with the standards set forth in (d) above.

The only test of the Insurance Commissioner's authority over Blue Cross contracts with hospitals is found in the case of *Pennsylvania Insurance Department* v. *St. Luke's Hospital*, 21 Commonwealth Ct. 10, 342 A.2d 773 (1975), in which the Court held that the refusal of the Commissioner to approve the contract in that case was not such a manifest and flagrant abuse of discretion or purely arbitrary execution of duty as to be reversible on appeal since that Court found that the reasons assigned for disapproval of the contract related to the rates of payment by Blue Cross to hospitals and justified the refusal. At the same time, however, the Court rejected the recommendations and guidelines which had been distributed by the Insurance Commissioner as a basis for refusal to approve the contract. This portion of the finding in that case is of substantial significance since the Commissioner had dis-

tributed to the press and to Blue Cross plans 71 guidelines which he had desired to have incorporated in Blue Cross contracts with its member hospitals. These ranged from matters relating to rates, to provisions for no smoking and the composition of the board of hospitals, and they clearly evidenced an intention on the part of the Insurance Commissioner to exercise the power to regulate hospitals under the Blue Cross contract. This power, except as to approval of rates, was rejected.

It is clear, therefore, that Pennsylvania hospitals are unregulated except as to the standards of treatment which are subject to inspection and recommendations for improvement. Hospitals are entitled to complete control of their charges and must obtain Insurance Department approval only of its rates of payment with Blue Cross. Unfortunately, this has permitted the Insurance Commissioner to review only the revenues flowing from Blue Cross and to ignore the financial requirements of hospitals for the real cost of community care.

The elusive influence of past Insurance Commissioners has prevented hospitals from being able to even challenge the lawfulness of the policies the Commissioner espoused since Blue Cross has refused to agree upon contractual provisions inconsistent with those policies.

There is no rate regulation of hospitals since their rates are not fixed. No agency is responsible for their financial stability. There is no statutory standard for the approval of rates of payment by Blue Cross and thus reasonableness is the only standard. The power to approve without the power to fix rates does not amount to rate regulation.

B. TRAVELERS IS DISTINGUISHABLE AND IN ERROR

The Lower Court clearly relied upon *Travelers Insurance Company* v. *Blue Cross of Western Pennsylvania*, 361 F. Supp. 774 (W.D. Pa. 1972), aff'd. 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1974), as the basis for stating that mandated cost ceilings on reimbursement

and the exclusion from the reimbursement formula of the cost of free care and capital expense had been mandated by the Insurance Department and were proper terms in the contract. The *Travelers* case on which the Court relied is distinguishable from this case and was wrong as a matter of law as to the McCarran-Ferguson[1] Act exemption and is not good authority in this case.

The rights of the Insurance Department with respect to member hospital contracts has been heretofore discussed, and it is clear that the Department had no right to mandate the recited provisions. Whatever contacts Blue Cross may have had with the Insurance Commissioner in this case, it is clear that he did not perform his official function of approving or disapproving, since no contract was ever agreed to. There is no evidence that he mandated the terms of the earlier contracts. The fact that the Court in *Travelers* misinterpreted the actions of the Insurance Commissioner as mandating terms in the contract certainly cannot be used against the Appellants in this case.

Travelers is completely inapposite. The suit was by a commercial insurer, and the hospitals supported Blue Cross. On the hearing on coercion, no evidence was produced to sustain that charge. That certainly is no basis for refusing a hearing in this case to prove the confiscatory nature of paying less than real cost.

Appellants contend that not only is *Travelers* distinguishable, but in addition, that the application of the McCarran-Ferguson Act was clearly wrong as a matter of law. The Nonprofit Hospital Plan Act exempts Blue Cross from the application of the insurance laws of the Commonwealth unless the particular statute specifically refers and applies to such a corporation: 40 Pa. C.S.A. 6103(a). Accordingly, unless the anti-trust aspect of insurance was prescribed by statute, the McCarran-Ferguson Act exemption was inapplicable: *F.T.C.* v. *National Casualty Co.*, 357 U.S. 560 (1958).

---

1. 15 U.S.C.A. 1012.

The only regulation of the anti-trust aspect of the insurance business in Pennsylvania when *Travelers* was decided[1] was the Act of June 5, 1947, P.L. 445, 40 P.S. 1151, et seq., which Act applied generally to insurance business but did not encompass Blue Cross activities because Blue Cross was not specifically included thereunder as required by the Nonprofit Hospital Plan Act. There was therefore no regulation at the state level of the anti-trust aspects of Blue Cross activities as required by the McCarran-Ferguson Act to be eligible for the exemption from the Sherman Anti-Trust Act.[2]

That there was no state action to exempt these provisions from Federal anti-trust scrutiny was held in the first *Travelers* case, *Travelers Insurance Company* v. *Blue Cross*, 291 F. Supp. 1109 (1969), wherein the Court stated:

> " . . . No case cited by the parties nor discoverable through extensive research reveals any authority ascribing 'state action' immunity either to a private entity or to the transactions of a state agency which were not mandated or directed by legislative enactment. That regulation and supervision alone do not constitute a delegation of governmental authority is well established (citations omitted) . . . the Pennsylvania Non-Profit Hospital Plan Act is completely silent in matters that have to do with restraint of trade . . . Blue Cross fails to meet the standards inherent in a 'state action' exclusion from the scope of the Sherman Act . . . and it has not been extended valid governmental authority to engage in anticompetitive practices . . . "

Anti-trust is not an issue in this case. The lack of state anti-trust regulation was not raised in *Travelers*. The matter is discussed here because of the continued reliance on *Travelers* to sustain the refusal of Blue Cross to pay its

---

1. By Act of July 22, 1974, P.L. 589, 40 Pa. C.S.A. 1171.1, et seq., Blue Cross has now been expressly included in Pennsylvania anti-trust regulation.

2. 15 U.S.C.A. 1, et seq.

share of the cost of community services. Such refusal cannot be sustained as mandated, since there is no power to mandate in the Insurance Commissioner. It cannot be sustained as part of a rate regulatory scheme since there is no regulation of rates of payment to hospitals, merely a right to approve or disapprove. It cannot be sustained by citing *Travelers*, since *Travelers* involved anti-trust and was in error even in the anti-trust field. Hospitals are not a rate regulated industry, and the Lower Court erred in relying upon such regulation as the basis for remedial legislation.

CONCLUSION

Judge Luongo, in the dissent below, recognized the confiscatory nature of the rates imposed on hospitals by Act No. 94 during the thirteen-month period if no new contract is finally negotiated. The failure of these rates to include a proportionate share of real cost to operate a hospital constitutes state imposition of rates at less than costs.

The community services performed by hospitals must be paid for by the community. As a matter of public policy, Blue Cross subscribers should carry their share of this community need. This is particularly so since such subscribers constitute the greatest part of the population able to pay for medical care.

If real costs are accepted as costs, and hospitals are being required to operate at less than cost, it is clear that Act No. 94 takes property without compensation in violation of the Fourteenth Amendment to the Constitution and abridges substantive contractual rights in violation of the Contract Clause.

There can be no justification of Act No. 94 as being part of a regulatory system governing hospital rates, first because rate regulation would not justify a requirement to operate at less than cost, and second because hospital rates and rates of payments by Blue Cross to hospitals are not regulated or fixed. The latter need only to be approved.

It is respectfully submitted that Act No. 94 is unconstitutional and that the order of the Lower Court should be reversed.

Respectfully submitted
JAMES H. STEWART, JR.
SPENCER G. HALL, JR.
NAUMAN, SMITH, SHISSLER & HALL
Attorneys for Appellants

TABLE OF CITATIONS

Cases:	Page
Denver Union Stock Yard Co. v. *U.S.*, 304 U.S. 470 (1938)	17
D. C. Transit System Inc. v. *Washington Metropolitan Area Transit Commission*, 466 F.2d 394, cert. denied, 409 U.S. 1086 (1972)	17
Frankfort Hospital v. *Greater Philadelphia Blue Cross*, No. 76–2049, before the Third Circuit Court of Appeals	
FTC v. *National Casualty Co.*, 357 U.S. 560 (1958)	25
Guest v. *Fitzpatrick*, 409 F. Supp. 818 (E.D. Pa. 1976)	20
Home Building and Loan Association v. *Blaisdell*, 290 U.S. 398 (1934)	17, 18
Louisville Joint Stock Land Bank v. *Radford*, 295 U.S. 555 (1935)	17, 18, 19
Pennsylvania Insurance Department v. *St. Luke's Hospital*, 21 Pa. Commonwealth Ct. 10, 342 A. 2d 773 (1975)	22
U. S. Rys & Elec. Co. v. *West*, 280 U. S. 234 (1930)	17
Travelers Insurance Company v. *Blue Cross of Western Pennsylvania*, 361 F. Supp. 774 (W.D. Pa. 1972), aff'd. 481 F.2d 80 (3d Cir. 1973), cert. denied, 414 U.S. 1093 (1974)	24, 25
Travelers Insurance Company v. *Blue Cross of Western Pennsylvania*, 291 F. Supp. 1109 (1969)	2, 25, 26
W. B. Worthers Co. v. *Kavanaugh*, 295 U.S. 56 (1935)	17, 18, 19

Federal and State Statutes:	
Act of July 22, 1974, P.L. 31, 40 Pa. C.S. §1171.1	5, 25
Act 94, Act of August 2, 1975, P.L. ____ Act 94, 40 Pa. C.S. §6101	1, et seq. 8
Nonprofit Hospital Plan Act, June 21, 1937, P.L. 1948, 40 P.S. §1401, repealed, and replead Act of November 15, 1972, P.L. 1063, 40 Pa. C.S.A. 6101, et seq.	22, 25
Social Security Act, Title XVIII, 40 U.S.C. §1395 X(v)(1)(A)	9

TABLE OF CITATIONS (Continued).

Statutes:	Page
Public Welfare Code, Act of April 9, 1929, P.L. 177, *as amended*, 62 P.S. 901	20
Reorganization Plan No. 2 of 1973, 71 P.S. §755–2	20
Act of July 15, 1976, P.L. ____ (No. 202) amending section 443.1 of the Public Welfare Code	11
Sherman Act, 15 U.S.C. §1	25
McCarran-Ferguson Act, 15 U.S.C. §1012	24, 25
Act of June 5, 1947, P.L. 445, 40 P.S. §1151, et seq.	25
Hill-Burton Act, 42 U.S.C.A. 291, et seq.	11
Constitution:	
Fourteenth Amendment to United States Constitution	
Miscellaneous:	
Factors Affecting the Costs of Hospital Care, Blakiston Co., Copyright 1954, published by Maple Press Company, York, Pennsylvania	7